MEDICARE REFORM DEJA VU 4 | SANTORUM OPPOSES DRUG PRICING PROPOSAL 14 | OBESITY UPDATE 9-11

HEALTH CARE NEWS

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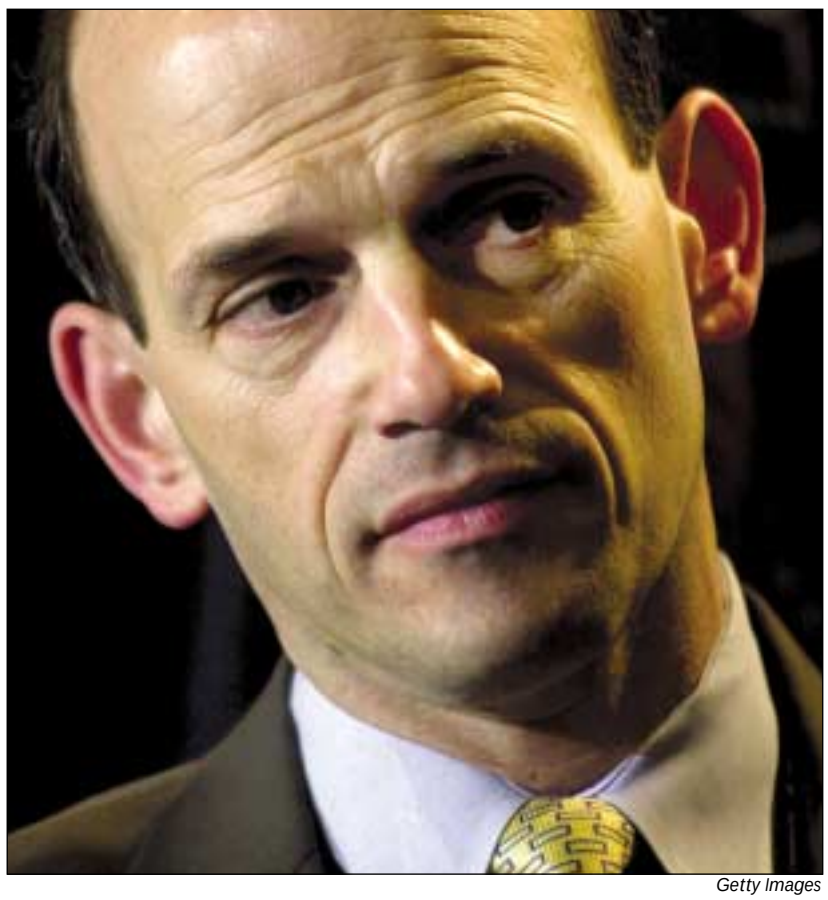
Maine Launches Controversial Health Care Plan



Getty Images

Maine Governor John Baldacci has come under fire for moving too quickly on Derigo Health, a universal health care plan one critic called a "political experiment with people's lives."

Conrad F. Meier

Maine's first-year Democratic Governor, John Baldacci, signed on June 18 a bill giving him something he asked for in early May: universal health care.

Trish Riley, director of the Governor's Office of Health Policy and Finance, explained to media representatives, "We propose the creation of Dirigo Health, an independent not-for-profit organization run by a five-person Board of Directors. It will contract with insurance carriers to provide a comprehensive benefit offered, at first, to individuals, self-employed persons, and small businesses with fewer than 50 employees."

In describing the administration's plan for financing the program, Riley said, "Subsidies will be provided on a sliding scale to those with incomes below 300 percent of the federal poverty level (FPL) or $55,000 for a family of four. We ask employers to cover 60 percent of the cost of coverage and to cover part-time workers who work more than 15 hours on a pro-rated basis. I hope we can find

DIRIGO continued on page 6

Florida Renews Disease Management Program

Conrad F. Meier

Florida officials have renewed an innovative disease management experiment offered through the state's Medicaid program by four of the country's leading pharmaceutical manufacturers. The two-year program would have expired on June 30.

Officials say the program—offered by Pfizer, Bristol-Myers Squibb Co., GlaxoSmithKline PLC, and AstraZeneca PLC—has improved patients' overall health. The four companies have guaranteed a combined total savings to Florida of $64.7 million over the two years ... or they'll pay the difference. Pfizer alone has guaranteed the state will see at least $33 million in savings.

An analysis conducted by researchers

FLORIDA continued on page 19

Florida Governor Jeb Bush was pitched on the disease management program in 2000. His administration supported the program's renewal.

Senate Battle Begins on Asbestos Fund

Conrad F. Meier

On July 14, the U.S. Senate began debate on the Fairness in Asbestos Injury Resolution Act of 2003, a measure aimed at addressing the nation's asbestos litigation crisis.

Introduced in May by Senate Judiciary Committee Chairman Orrin Hatch (R-Utah), the measure was approved by that Committee on July 10, after a flurry of hearings and markup sessions were held to work out the details of a proposed $108 billion national compensation fund, the centerpiece of the measure.

Asbestos injury compensation claims have been backing up in the court system for years; the fund has been proposed as a way to resolve claims more quickly.

Asbestos was widely used for fireproofing and insulation until the 1970s, when scientists concluded inhaled fibers could be linked to such illnesses as cancer and pulmonary disease.

The proposed compensation fund, to be

ASBESTOS continued on page 16

Seniors Worry about Drug Benefits

Grace-Marie Turner

A Zogby International opinion poll, conducted June 18-21 and released by the Galen Institute, found overwhelming public support for private-sector options in Medicare ... as well as fear the complex drug benefit crafted by the Senate could be worse than the coverage many seniors now have.

The poll suggests voters would like the option of enrolling in private plans to provide overall health coverage in Medicare,

SURVEY continued on page 15

INSIDE HCN

2 House GOPs: Free-Market Medicare
3 Generics Tacked on to Medicare Reform
5 Grassley Defends Senate Medicare Bill
6 Experts Deride Dirigo Health
9 Don't Target Fast Food for Obesity
13 Consumer Choice Matters
17 Galen Report
18 Apologies to My Grandchildren

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CAPITOL HILL **NEWSWATCH**

House Republicans Demand Free-Market Medicare

Conrad F. Meier

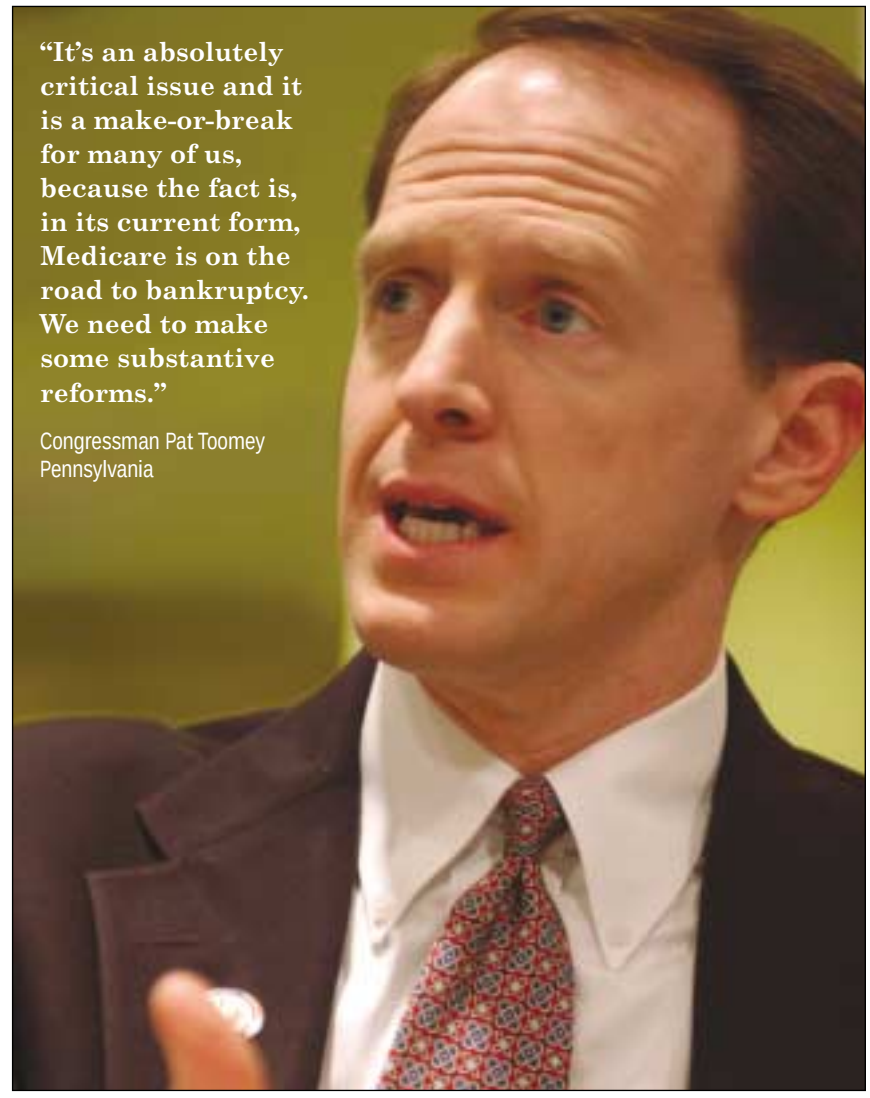
Forty-four House Republicans have promised to beach President George W. Bush's Medicare prescription drug plan if it does not include free-market reforms.

They say the drug benefits will cost too much and drive Medicare even closer to insolvency. The Congressional Budget Office has estimated the bill will cost $400 billion over the first 10 years.

"It's not clear how expensive it's going to be, and it's going to further aggravate the long-term liability of Medicare, and will require huge tax increases in the future on our children and children's children to pay for this benefit," said Michael Franc, an expert on congressional procedure at The Heritage Foundation.

In a July speech to Miami seniors, Bush said, "Medicare does not have prescription drug benefits, as you know. We've got to change that. If medicine is changing, we want Medicare to change with it, on behalf of the senior citizens all across the country."

And while Republicans agree, they are concerned the President's proposal will be too expensive. They predict that once the government subsidizes drug coverage, demand will increase and costs will exceed all expectations.


"It's an absolutely critical issue and it is a make-or-break for many of us, because the fact is, in its current form, Medicare is on the road to bankruptcy. We need to make some substantive reforms."
Congressman Pat Toomey
Pennsylvania

Roll Call

One-Vote Margin

The Medicare bill passed in the House by one "yea" late in June after members pulled an all-night session.

Following the vote, the 44 House Republicans, including many who had voted for the bill, wrote a letter to House Speaker Dennis Hastert (R-Illinois), threatening to kill any final Medicare drug bill unless it clearly allows for free-market competition.

One of the signatories, Representative Pat Toomey (R-Pennsylvania), said, "It's an absolutely critical issue and it is a make-or-break for many of us, because the fact is, in its current form, Medicare is on the road to bankruptcy. We need to make some substantive reforms."

The letter to Hastert also stated, "Should this reform be removed or weakened, we cannot as a matter of responsible public policy support a bill to add a prescription drug benefit to Medicare which would accelerate the insolvency of this vital program."

The Senate version of the measure contains no free-market competition provisions. A bill reconciled between the House and Senate must pass both chambers before heading to the President's desk.

The Republicans say they want to give Medicare recipients the right to buy alternative health coverage outside of Medicare starting in 2010. The goal is to give seniors the same medical coverage options members of Congress now enjoy with the Federal Employees Health Benefits Program (FEHBP).

Senator Ted Kennedy (D-Massachusetts) has stated he opposes free-market reforms and is banking on getting his way in the final reconciled bill. As a matter of record, Kennedy is opposed to privatizing any aspect of the Medicare program.

Timetable

The discontent among House Republicans challenges the President's top legislative priority and an important part of his strategy to gain domestic policy support in advance of his bid for re-election. Eventually, since Bush can't have it both ways, the White House will have to choose between Senate Democrats and House Republicans. Just when all this will come together is difficult to predict.

Tom Miller, director of health policy studies at the Cato Institute, told *Health Care News*, "A conference report will not be finished before early September. There is a 50-50 chance the House will vote down the original version of the conference report when it comes back from the House-Senate committee."

Miller also said, "I then expect a revised version of the conference report, which then would move closer to the somewhat better aspects of the House bill, to finally be approved after a lot of tugging and pulling, before the end of September at the earliest, and in early November at the latest."

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Generics Added to Medicare Reform Measure

Conrad F. Meier

The Senate voted 94-1 on June 19 to approve a proposal aimed at speeding the market entry of generic drugs by eliminating some patent extension practices used by brand-name drug manufacturers.

Under current law, brand-name companies can obtain from the Food and Drug Administration (FDA) multiple 30-month stays of their patents in an effort to protect their intellectual property from patent violations.

The Senate amendment, also passed by the Senate Health, Education, Labor and Pensions Committee as a separate bill (S. 1225), would amend the 1984 Hatch-Waxman Act to allow brand-name companies only one 30-month extension in cases where the brand-name company claims patent infringement by a generic drug company. Senator Orrin Hatch (R-Utah) cast the only dissenting vote.

The Senate bill expands on new FDA regulations announced by President George W. Bush in late June. Those regulations will allow brand-name pharmaceutical companies only one 30-month delay in patent infringement cases and will make brand-name pharmaceutical companies liable for criminal charges if they make false claims in the patent process.

Senator Charles Schumer (D-New York)

Senator Judd Gregg (R-New Hampshire)

Unlike the Senate measure, however, the Bush rule does not eliminate a provision of current law that gives the first generic form of a brand-name drug to come to market 180 days of exclusivity. The Senate bill would eliminate the exclusivity period if a generic drug company fails to come to market with its product in a timely manner, or if it is determined the company had entered into an anticompetitive deal with a brand-name manufacture.

The Bush rule also does not allow generic drug makers to file counterclaim lawsuits. Such suits would be allowed, although not without limits, under the Senate measure.

Reaction

Senator Charles Schumer (D-New York), one of the proposal's sponsors, said the changes would save consumers between $60 and $70 billion over the next 10 years and could shrink Medicare costs by $18 to $20 billion. According to reports in the *New York Times*, Schumer said the plan would do away with the "frivolous patents, lawsuits, and legal mumbo-jumbo" used by brand-name drug makers to delay the availability of generic medicines.

Senator Judd Gregg (R-New Hampshire), also a sponsor, said the measure would make "generic drugs more available to consumers on a faster time frame" but would not limit "innovation in our brand-name [drug] companies."

"It is important that the tilt in incentives not be given to the generics industry, since it is the innovative brand-name industry that researches and develops new medicines that patients need."

Jeff Trewhitt
Pharmaceutical Research
and Manufacturers of America

Jeff Trewhitt, spokesperson for the Pharmaceutical Research and Manufacturers of America, was less certain of the measure's effects on the industry. He warned, "It is important that the tilt in incentives not be given to the generics industry, since it is the innovative brand-name industry that researches and develops new medicines that patients need."

Uncertain Chances

According to the *Los Angeles Times*, the measure was approved as part of the broader Medicare reform bill because some legislators and activist groups have complained the bill, although it provides new insurance for drug expenses, would do little to solve the related problem of soaring prescription drug costs.

Although similar legislation passed the Senate last year and died in the House, the bill's Senate sponsors are more optimistic this time around. They have changed the bill to include provisions sought by House Republicans.

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Consumer Directed Health Care Conference Scheduled for November 2003

Conrad F. Meier

Major issues across the health care system—rising health care costs, quality of care, and patient outcomes—are on the minds of consumers. Public opinion polls place the issue second only to concerns about the economy.

Politicians face criticism for not becoming part of the solution. Insurance companies are accused of not doing "enough" to help ease the financial crunch. Employers are being blamed for passing on escalating costs to their employees. And through all of this, consumers are simply trying to take control of their own care.

According to Greg Scandlen, director of the Center for Consumer Directed Health Care at the Galen Institute, "Health insurance products designed to give consumers a bigger say in their coverage—and consequently become more discriminating consumers of health care services—are multiplying at a dizzying pace."

Consumerism is becoming a widely accepted approach in the health care industry. How much influence do consumers have now ... and what can be done to satisfy the growing demand for still more consumer control?

The Emergent Group will address those issues and more at the 2003 Fall Consumer Directed Health Care Conference and Expo (CDHCC) on November 10-12, 2003 at the Gaylord Opryland Hotel and Resort in Nashville, Tennessee. The first CDHCC, held in April 2003, attracted more than 700 attendees and 45 exhibitors. (See "Riding the Wave of Consumerism," *Health Care News*, July 2003.)

The CDHCC gathers together under one roof the consumer-driven health care industry's key stakeholders: employers, providers, benefit plan managers, and the leading technology, product, and solution providers.

CDHCC's 12 plenary sessions, more than 30 substantive sessions in the pre-conference and three concurrent tracks, make it possible to understand the critical issues, see real solutions in action, and get a better understanding of how change will affect us tomorrow and in the future.

Some of those sessions include:

- Employers Dealing with Rising Health Insurance Premiums
- Unhappy Employees Dealing with the Costs of Reimbursement
- Lesser Options for Employees/Prescription Drug Plans
- The New Frontier: Modeling Consumerism from the Payor Community
- The 'Real World' of Patient Directed Health Care
- Business and Government Look at Consumerism

The Emergent Group, LLC is an event management company offering a full range of management services and partnership opportunities. The company produces several industry-specific events including the CDHCC, Healthcare Delivery Solutions Congress (HDSC), and The Emerging Healthcare and Innovations Congress (TETHIC).

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visit The Emergent Group Web site at **http://www.theemergentgroup.com**. For more information about the CDHCC, visit **http://www.cdhcc.com** or contact Leanne Forbes at **leanne@theemergentgroup.com**.

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ANALYSIS

Medicare Reform Measure Repeats Mistakes

Conrad F. Meier

In 1988, President Ronald Reagan signed the Catastrophic Health Care Act—sweeping Medicare reform legislation meant to respond to what legislators saw as overwhelming demand for government-provided health care benefits.

But a revolt erupted once the public realized the new entitlement came with a steep price, with seniors expected to pay higher premiums for fewer benefits. The Act also employed means-testing to curtail benefits, so all but the lowest-income seniors shouldered new financial burdens under the plan.

Former House Ways and Means Committee Chairman Dan Rostenkowski (D-Illinois) was mobbed by more than 50 angry seniors in downtown Chicago. One senior citizen made media history by attacking Rostenkowski with her umbrella. Hundreds of thousands of letters protesting the new law were delivered to the floor of Congress.

In a rare and rapid about-face, Congress repealed the legislation within a year.

Misreading the Public

The Medicare reform legislation now under discussion in Congress has set the stage for a repeat of one of history's most obvious policy-making blunders. While opinion polls report the public's concern over the health care system as a whole and Medicare in particular, federal legislators have moved ahead on a schedule that appears to be set more by political priorities than by sound policy considerations.

According to Sue Blevins, founder and president of the Institute for Health Freedom in Washington, DC, "Congress seems to be reacting to what it thinks is the public's overwhelming demand for more government regulation and intervention into the Medicare program."

"The Medicare reform legislation now under discussion in Congress has set the stage for a repeat of one of history's most obvious policy-making blunders."

But, Blevins notes, citing a recent survey released by the Galen Institute (see "Seniors Worry about Drug Benefits," page 1), "66 percent of respondents said they are worried a government-provided prescription drug benefit might mean some people could lose their private health care coverage and become dependent on government funding.

"That's exactly what happened to seniors when Medicare was passed more than 30 years ago," Blevins points out. "They lost their independence regarding health insurance options. And consequently, health care costs have skyrocketed for all."

Blevins predicted already-weak support for the Medicare reform measure currently being debated in Congress will plummet once the public, and seniors in particular, realizes the $400 billion cost projection is nothing more than a down payment.

Seniors Given Short Shrift

When legislators crafted Medicare in 1965, they did not anticipate pharmaceutical treatments would become popular, effective alternatives to hospitalization and invasive surgery. So they didn't include in Medicare coverage for drugs used in outpatient settings. Private-sector insurance plans long ago adapted to changes in health care by covering medications.

The positive spin lawmakers have put on the pending Medicare reform proposals obscures a financial reality awaiting seniors and all U.S. taxpayers: If a reform measure is passed, the nation will be exposed to potentially catastrophic costs that will be passed on to the grandchildren of today's and tomorrow's seniors.

The House and Senate still must reconcile the plans each chamber passed in late June. Both bills contain serious policy flaws:

- *Low-balling the costs.* Though lawmakers claim they can provide drug coverage to seniors at a reasonable expense, they rely on accounting tricks that underestimate the real cost. The $400 billion cost over the next 10 years is achieved by delaying the effective date of the benefit for three years. In 10 years the expected cost more than doubles—the program would cost more than $900 billion in the subsequent 10 years.
- *Casting a wide net.* Rather than target the prescription drug benefit to the one-fourth of seniors currently without drug coverage, both plans offer something for everyone in Medicare. That approach will encourage employers to drop drug insurance for the 31 percent of seniors who now get their drugs as a retirement benefit. The Congressional Budget Office estimates more than one-third of retirees would lose their company coverage and be

RUSSMO'S RANTS

I BELIEVE MEDICARE REFORM ELIMINATES FREE MARKET HEALTHCARE.
I BELIEVE MEDICARE REFORM EXPANDS FREE MARKET HEALTHCARE.
OBVIOUSLY WE BOTH CAN'T BE RIGHT...
BUT THERE IS ONE THING WE AGREE ON...
THEY CAN PAY FOR IT
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RUSSMO 7/03

Medicare Reform Deja Vu?

"The votes tell the story. On June 2, 1988, the House passed the Catastrophic Health Care Act 328-72. On Wednesday [October 4, 1989], the House voted to repeal it 360-66. Rep. Brian Donnelly, a Massachusetts Democrat who co-sponsored the repeal, saw the vote as evidence of a responsive Congress at work. 'We made a mistake last year,' said Donnelly, who backed catastrophic care the first time around. Even House Speaker Tom Foley, a man celebrated for his reasonableness, acknowledged last week that 'in the future, the House will move very cautiously on any long-term health care proposals.'"

Excerpted from Steve Daley, "Rabid Eagerness to Please Becoming Theme of 101st Congress," October 8, 1989, Chicago Tribune.

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of 25 Years Ago

forced into the Medicare plan.

- *Benefit gaps.* Like 1988's Catastrophic Health Care Act, the new reform proposals shift additional costs to seniors. In the Senate plan, recipients would pay their first $275 in drug costs out of pocket each year. Following that, the government picks up half the cost, but only until the annual drug bill hits $4,500. Then coverage stops until a senior has spent $3,700. Then the plan covers 90 percent of costs.
- *Wishing won't make it so.* Both bills hope to entice private insurers to compete with one another to offer standalone drug benefits. Private health insurance plans are expected to provide a needed benefit to seniors while keeping costs low and still turning a profit. It's difficult to imagine how that can happen. Most brand-name drug companies already offer deeply discounted prescription drugs and prescription discount cards through their own assistance programs; they already discount drugs by 20 percent for state Medicaid beneficiaries; and they are under heavy pressure to offer additional rebates to state-run discount drug programs. It is unlikely they will agree to discount drugs for private insurance plans as well.
- *Reform in name only.* Neither bill currently under consideration will bring Medicare spending under control. The Senate measure promotes no meaningful financial reforms, while the House postpones any meaningful change until 2010.

Unwanted Consequences

It's anybody's guess what Medicare reform will look like next week or next month, as Senate and House leaders try to reconcile the two measures. But if the result includes a prescription drug plan anything like what's currently under consideration, the repercussions will be felt worldwide.

Writing in the "Health Care Symposium" feature of *National Review*'s June issue, Grace-Marie Turner, president of the Galen Institute, warns, "today, the United States remains the only major nation in which the bulk of the health care market is not restricted by government price controls. Consequently, we pay a disproportionate share of development costs for new drugs and devices, bearing the burden for other rich countries such as Canada, Germany, France, and the U.K.

"If the United States, too, defaults to the failed European model [price controls], where are we—or they—to turn for medical innovation?"

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Senator Defends Medicare Reform Measure

Conrad F. Meier

Senator Chuck Grassley (R-Iowa), chairman of the Senate Finance Committee, told *USA Today* the Senate's Medicare reform measure "targets the poorest and the sickest. It gets the most bang for the buck. It keeps traditional Medicare intact. It injects competition to improve benefits and control costs."

Grassley defended even the drug coverage gap, saying "Congress approved $400 billion over 10 years for a Medicare drug benefit. It's a lot of money, yet it doesn't buy blanket coverage. Even with older Americans sharing the costs, this amount stretched only so far. Over the next 10 years, older Americans will spend $1.8 trillion on prescription drugs. Because of this huge expense, our bill targets the most help to the poorest, sickest seniors. And the coverage gap isn't likely to affect the vast majority. I wish it didn't affect anyone at all, but the budget limit is the law."

In an effort to control costs, the Senator said, "we promote the sale of generic drugs and inject competition into Medicare. We worked hand in glove with the non-partisan Congressional Budget Office to structure our bill to contain costs. The bill requires private plans to compete for Medicare's business in each region. Private companies have an incentive to keep costs down. The CBO says our structure will work. Its people are the experts, and they have no political ax to grind."

As for the delayed start of the drug program, Grassley explains, "We're adding the biggest benefit to Medicare in its history. According to government agency experts, it's logistically impossible to set up this huge new program and enroll millions of people before the end of 2005."

Medicare required structural change, Grassley said, outlining how that is accomplished in the Senate proposal. "We included several substantial structural improvements. For those who choose the new Medicare option with drug coverage, we get rid of duplicative, irrational deductibles. Traditional Medicare hospital coverage has a deductible for each illness—$840 in 2003. A beneficiary admitted to the hospital multiple times ends up paying this deductible more than once a year.

"There's also an annual deductible for Medicare physicians' coverage," says Grassley. "That's expensive and confusing. Under the new Medicare option, people will pay one deductible for all services, just like most other Americans."

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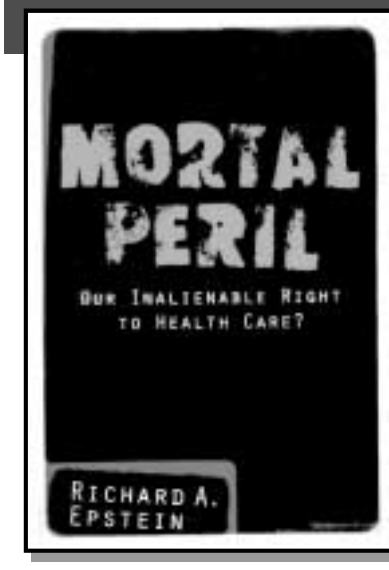

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Dirigo

Continued from page 1

our way to make good on the promise of our state's motto for which this plan is named: Dirigo—Maine leads."

Dirigo Details
The bill is intended to provide an estimated 180,000 uninsured people with access to medical insurance in a sweeping health insurance plan mirroring failed attempts in Kentucky, Tennessee, and Washington. The vote to pass in the House was 105-38, and the Senate approved the measure 25-8, allowing the state to start organizing the program within 90 days.

The plan creates a new bureaucracy to secure private health insurance for middle- and low-income residents. According to the plan's advocates, all Maine residents who cannot afford health insurance would have access to low-cost coverage by 2009. The plan is expected to go into effect next year even though Baldacci admitted publicly the bill is flawed. He has asked legislators to pass it and fix it later.

"It is time that the people of Maine demand that their governor and legislators practice 'evidence-based' public policy. Let's have no political experiments with people's lives."

Betsy Chapman, chairman
Maine Public Policy Institute

Participants would be charged subsidized premiums according to their ability to pay and the amount of coverage purchased. Funding would come from a patchwork of sources, including a tax on insurance companies and the estimated $80 million the state expects to save each year by eliminating unreimbursed medical expenses incurred by uninsured residents.

"An Illusion," Experts Warn
State politicians and health care experts alike say the program is doomed to failure. "This bill is an illusion and a promise not fulfilled," Assistant House Minority Leader David Bowles (R) said before the final vote.

In a forum at the Greater York Region Chamber of Commerce, York Hospital President Jud Knox called the concept laudable but added it will not work.

"If I put a plan like this before the York Hospital Board, I'd get nowhere," Knox said. "Is this plan going to cost small business more? I don't know if it will for coverage, but I am convinced it will cost more somehow, through tax dollars or some other way. The bill is fraught with unknowns."

What happens in years two and three no one, including the Baldacci administration, seems to know. The bill's language says it will depend on a reduction in bad debt and charity care, but contains no mechanism for collecting or reallocating such funds. No plan has been outlined for long-term sustainability.

Arthur Levin, director of the New York-based Center for Medical Consumers, says calling the program "voluntary," in that businesses can choose to opt in or out, is misleading. "Small businesses are going to get pressure from their employees to do this if they don't have insurance now. This plan calls for small businesses to pick up 60 percent for employees who work over 20 hours, and for their families," said Levin, adding, "As you know, this state is full of small businesses."

Levin also noted, "This was a flawed plan from the get-go. The governor has been convinced risk pools do not work, but they are working in 31 states who have cut insurance costs by 41 percent or more. There's a school of thought up here that people on charity care will all of a sudden step up and start paying for insurance. Even if it was made less expensive, we'd still be more expensive than any state around."

"Maine is moving very fast toward government-run single-payer health insurance," warns Scott K. Fish, director of special projects for the Maine Public Policy Institute. "The revised Maine Rx program is part of that movement. Maine's new Dirigo Health Plan is another part."

Betsy Chapman, chairman of the Institute's board of directors, asked in a May 20 article in the *Kennebec Journal*, "What is the rush? It took decades to get into the current quagmire. Governor Baldacci wants to pass the most sweeping changes to our health care system in history ... and we have a month to do it?

"The governor's health care proposal is an experiment," she continued. "The governor can't promise his plan will perform as advertised, because he can't point to anywhere where it has worked.

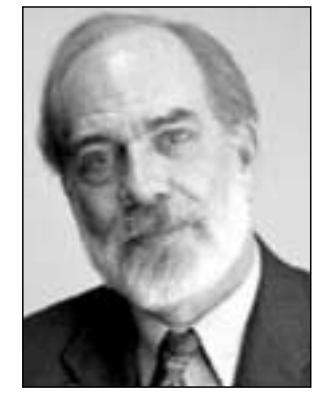
"If his plan can't stand the deserved careful study and consideration of those who will be directly affected by it, the plan must be flawed. It is time that the people of Maine demand that their governor and legislators practice 'evidence-based' public policy. Let's have no political experiments with people's lives."

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

Experts Deride Dirigo Health

Conrad F. Meier
Maine Governor John Baldacci's universal health care proposal attracted the attention of experts from across the country ... but their reviews were not the glowing ones the governor sought. Like the program's Pine State critics, outside observers warned the program would be costly and ineffective.

Merrill Matthews


Greg Scandlen

"Billboard for Adverse Selection"
"The proposal includes tax-financed subsidies for everyone with incomes below 300 percent of the federal poverty level or $45,750 for a family of three," explained Greg Scandlen, director of The Galen Institute's Center for Consumer Driven Health Care. "Yet the median household income in Maine is $37,240."

The state "seems to think it will pay for the subsidy by 'recovering' millions in freed-up money from bad debts caused by unreimbursed care for the uninsured," he continued. "But the subsidy isn't confined to the previously uninsured. It is available to everyone meeting the income threshold—well over half the state population."

Morever, suggests Scandlen, "The program is a huge billboard for adverse selection. It provides no incentive for people to sign up while they are young and healthy, but allows them to wait until they know they need services before enrolling. There is no waiting period for pre-existing conditions, and though the report doesn't specify premiums, it will presumably be community-rated, meaning everyone pays the same premium regardless of risk factors such as age."

Scandlen warns, "Healthy people can decline to get coverage, knowing that if they ever get sick they can be covered immediately at no extra cost. There is absolutely no advantage in pre-enrolling, especially not if the employer pays only 60 percent of the cost of coverage, leaving another 40 percent for the worker to pay. With the younger people out of the insurance pool, premiums will skyrocket, making coverage unaffordable for everybody."

"Awesome Delegation of Discretionary Authority"
Lee Tooman, vice president of government relations for Golden Rule Insurance Company, told *Health Care News*, "Say what you want about last year's effort in Oregon to pass universal health care—at least you knew what you were voting for.

"By contrast, Maine's bill represents an awesome delegation of discretionary authority to unelected agency bureaucrats. The bill empowers the government in an unprecedented way to manipulate both the health care delivery and health care financing systems in the state.

"A long time ago," Tooman confides, "an actuary told me there are only two scenarios in which community rating works: either you force people to buy the insurance or you subsidize it so heavily people would be foolish not to buy it. Maine is going to try subsidies first. My guess is this will not work and the next step will be an employer mandate."

Tooman concluded, "One of my favorite provisions of the bill says that, to the extent necessary to formulate a proposed plan allocating costs and services, such collaboration must displace competition in affected health care markets. Sounds like command-and-control regulation to me. A mini-version of national health care."

New Hampshire the Next Haven?
Merrill Matthews, director of the Council for Affordable Health Insurance (CAHI), sees other potential consequences of the Dirigo Health Plan. He told *Health Care News*, "Even though Maine is next to Canada, and gets a lot of business from Canadians coming south of the border to get care they can't get in Canada, the governor and state legislature haven't learned a thing. Were the state to actually implement the plan, not only Canadians would be traveling south, but Mainers will be joining them—heading to New Hampshire."

Matthews predicts, "The universal portion of the plan will never be implemented because it is unworkable and unaffordable, a fact Governor Baldacci will be admitting in a few years ... if he is still in office."

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

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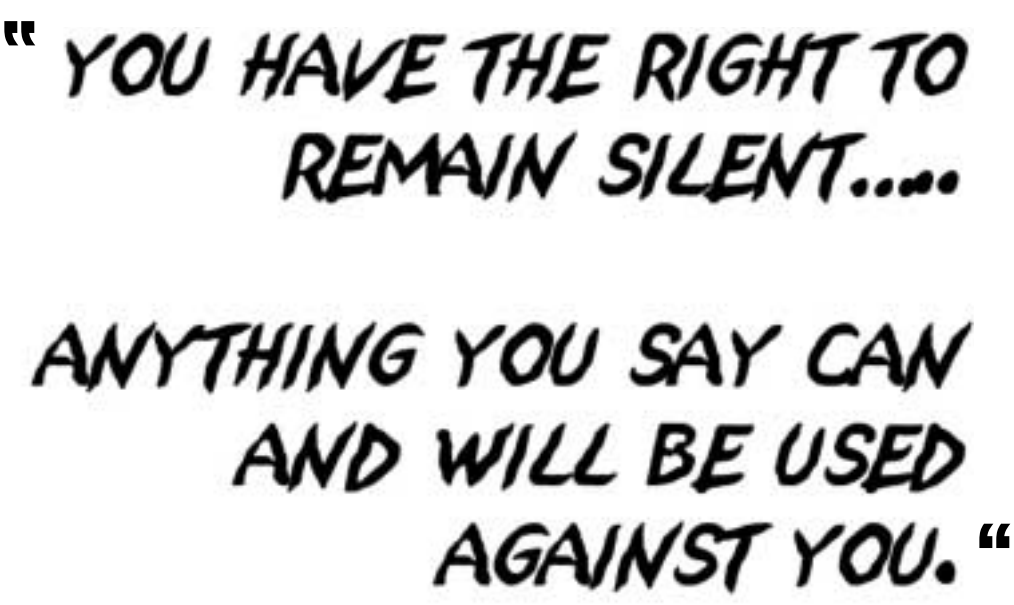

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OPEN LETTER

Don't Target Fast Food for Obesity Problem

TO:

MAY 29 2003

The Honorable Tommy G. Thompson
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Thompson:

This letter is in reference to your recent public comments on ways to combat obesity and promote healthier lifestyles among the U.S. population.

While the nonprofit groups whose names appear below appreciate the concern by the Department of Health and Human Services for U.S. consumers, we would like to share our own concern about the focus of recent interviews as well as some of the suggested remedies in helping consumers with weight problems.

In a recent CNN interview (May 13, 2003) and a report in *The Washington Post* (May 14, 2003), your comments seem to suggest that the food industry—in particular, fast food—is the principal target of the agency's interest in combating obesity. In the CNN interview you also proposed food companies and restaurants diversify their menus and encourage their customers to eat healthy foods and to exercise.

With the clamor from some activist groups for government to "do something" about obesity, we would like to urge caution in perhaps inadvertently promoting a climate for frivolous lawsuits and campaigns for government mandates that affect consumers' choices and pocketbooks.

First, as you know, most physicians, dietitians, nutritionists, and other scientists agree obesity is a highly complex problem arising from a multiplicity of contributing factors, such as genetic, socioeconomic, medical, dietary, lifestyle-related, psychological, and others.

Some factors relate to general trends in society, such as more sedentary lifestyles—more time on computers and watching TV, less physically demanding work, greater affordability of automobiles for more people, more time spent on longer commutes, etc. Other lifestyle trends—such as both parents working—create time pressures that have dramatically increased the incidence of food prepared outside the home. The greater affordability of food than was the case even 20 years ago may also be a factor.

Second, the focus on fast food as the easy culprit overlooks the findings of many recent studies that physical inactivity by consumers is a major health risk. Overweight and inactivity often go hand-in-hand, but the almost exclusive focus on weight loss in the media can be counterproductive. According to many prominent researchers, lack of exercise has more to do with poor health and increased mortality risk than being overweight. (See, for example, studies by the Cooper Institute.)

Third, we are especially concerned about the comparisons of obesity to smoking in many public forums. Indeed, a recent analysis underwritten by the Centers for Disease Control and Prevention uses that inappropriate comparison to advocate that strategies used to combat smoking be used to attack obesity.

Food is not the same as cigarettes. Tobacco is not a necessity—food is.

Telling people that food is the problem and they are the victims of food purveyors may be counterproductive in getting people to take responsibility and control by eating more balanced diets and by exercising more. It may also further encourage class-action attorneys to instigate even more McDonald's- and Oreo-type suits.

With a steady drumbeat calling for the same types of programs for obesity as were used to tamp down smoking, policy makers should be distancing themselves from those analogies instead of embracing them.

With large monetary incentives for such lawsuits, the trend will continue, and every day consumers will pay higher prices due to higher costs of doing business, as well as restrictions on marketing and products.

Fourth, as taxpayers, we are also concerned that the sudden popularity of instituting another "sin tax" is driven not so much by health concerns as by budget shortfalls in many states. While that issue was not mentioned in the coverage of your remarks, activist groups promoting the fast food/obesity connection are pushing for such "disincentives."

In addition, the claim that consumers have to endure higher taxes on their food so that health costs can be recovered for government-run health care programs has to be viewed somewhat skeptically, since significant amounts of money from taxes on cigarettes and the so-called tobacco settlement (where similar claims have been made) have been used for projects unrelated to health care.

Also, many taxpayers and consumers, shocked by the enormous payouts to the trial lawyers involved in the tobacco suits, may be unconvinced that lawsuits against the food industry would do anything but line the pockets of lawyers.

Fifth, while we support private initiatives that inform citizens about nutrition and health, the responsibility for a healthy diet and lifestyle still lies with the individual. Promoting a view that citizens and their families are the helpless victims of the fast-food industry flies in the face of both fact and common sense.

The suggestions that restaurants and food companies should encourage their customers to exercise more is unpractical at least. Most customers will preserve their right to make their own decisions, and might consider it not only patronizing but rude if restaurants start preaching to their customers about how much they should exercise—and how much they should weigh. Will servers begin to ration overweight customers? Presumably, this strategy would be recommended for those restaurants serving customers at the lower end of the economic scale. Would the government also exhort high-priced restaurant chefs to equally "educate" their customers?

You also called on restaurants to provide more menu choices. Most restaurants already provide a wide variety of foods; even so-called fast-food restaurants have extended their choices to attract health-conscious or vegetarian customers. However, restaurants cannot force customers to go for the salad if they want a burger with fries. In a market economy, producers will cater to the wishes and demands of consumers. In today's marketplace, consumers have a range of food choices and a range of prices for food.

It should also be recognized that people's attitudes toward food are important. Food is not purely about nutrition—for most people it is also about enjoyment of tastes, flavors, and often enjoying the company of friends or relatives. However, too often government and public health professionals overlook those important aspects of eating.

Reaching out to consumers who seek help for weight problems is important. However, we are concerned that your good intentions to persuade people to do what is best for them is focusing on the easy targets—fast-food companies—which may deflect attention from the complexity of the obesity problem, as well as encourage frivolous lawsuits and misguided tax proposals.

Sincerely,

Frances B. Smith
Executive Director
Consumer Alert

Dennis Avery
Director
Center for Global Food Issues - Hudson Institute

Paul J. Gessing
Director of Government Affairs
National Taxpayers Union

Gregory Conko
Director of Food Safety Policy
Competitive Enterprise Institute

Ruth Kava, Ph.D., R.D.
Director of Nutrition
American Council on Science and Health

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OBESITY AND GOVERNMENT

Keller, Kraft Weigh in on Obesity

By Conrad F. Meier

U.S. Rep. Ric Keller (R-Florida) and Kraft Foods Inc. have launched separate efforts aimed at a similar goal: to help Americans take more personal responsibility for their waistlines.

Keller is the sponsor of H.R. 339, the Personal Responsibility in Food Consumption Act. Introduced in January, the measure has attracted 66 cosponsors. In mid May, the measure was referred to the Judiciary Committee's Subcommittee on Commercial and Administrative Law, which held hearings in June.

Kraft Foods Inc.—makers of Kraft cheese, Nabisco cookies and crackers, Oscar Mayer meats, and Post cereals—announced on July 1 it is taking steps to help fight obesity in children by reducing portion sizes, eliminating the company's in-school marketing program, and educating consumers.

Personal Responsibility

Keller's bill shields manufacturers, distributors, and sellers of food and beverages from lawsuits blaming them for "weight gain, obesity, or a health condition related to weight gain or obesity." Keller—who figures he's about 20 pounds over his ideal weight—thinks consumers should stop blaming "fast" food purveyors and "junk" food manufacturers for their weight issues.

"We believe there should be common sense in a food court, not blaming other people in a legal court whenever there is an excessive consumption of fast food," Keller said at an Orlando news conference when he introduced the bill. "We think most people understand it's common sense that if you eat unlimited amounts of supersize fries and milkshakes and Big Macs ... that can possibly lead to obesity and things like diabetes and cardiovascular disease."

Keller introduced his bill five days after a federal judge in New York threw out a class-action lawsuit that blamed McDonald's food for children's health problems. (See "Obese Kids Re-Plead Their Case," *Health Care News*, April 2003.)

Testifying before a June 19 subcommittee hearing, Christianne Ricchi, owner of Washington, DC's i Ricchi Ristorante, supported Keller's measure. "Personal responsibility, moderation, and physical activity are all key ingredients to a healthy lifestyle," she pointed out. "To solely target the restaurant industry is overly simplistic."

Product Changes

Of course, those who file suit on behalf of obese clients aren't targeting only the restaurant industry, but food purveyors generally. Some observers say that's why Kraft Foods announced on July 1 a first-of-its-kind effort to help consumers tackle obesity, especially among children.

Kraft spokesman Michael Mudd, senior vice president for corporate affairs, explained, "We want to make sure that what we sell and how we sell it are responsive to changing patterns of diet, activity, and health."

Kraft plans to assemble an advisory council of international experts on behavior, nutrition, health, and communications. The council will recommend improved nutritional content for products and the development of alternative products where appropriate. It will, for example, determine the appropriate calorie content or other health standard for snack-sized packaged foods like Oreo cookies.

> **"What people eat is ultimately a matter of personal choice,but we can help make it an educated choice."**
>
> **Roger Deromedi**
> co-CEO Kraft Foods Inc.

Kraft says it hopes to develop its standards by the end of the year and implement them over two to three years. Kraft intends to downsize existing products that are bigger than its council recommends. The standards likely will vary among product types, Mudd said, with more calories allotted for meals than for snacks or desserts.

Marketing Changes

Kraft also said it will eliminate its in-school marketing promotions: book covers and posters, sports arena scoreboard sponsorships, contests, and free product samples. School vending machines will continue to be stocked with Kraft products, although the advisory council could decide some snacks offered are inappropriate and should be pulled.

Some question the company's motives but applaud the potential result.

Dr. Henry Anhalt, director of pediatric endocrinology at New York's Infants and Children's Hospital of Brooklyn, said he thinks Kraft is trying to avoid lawsuits such as those that have hit the tobacco industry. But he added, "Although I may question what their motivation is, anything that can perhaps decrease portion sizes and caloric intake in kids can have dramatic effects on obesity."

Mudd said the company is making the changes because it's the right thing to do, but "If it also discourages a plaintiff's attorney or unfair legislation, that's just fine with us."

Dr. Michael Arnold Glueck, a syndicated columnist who writes on medical-legal policy issues, told *Health Care News* lawsuit avoidance should not be Kraft's goal. "If you say and do nothing they will sue for negligence," he noted. "If you respond with a sensible solution, they will interpret it as an admission of prior guilt and complicity and sue you anyway."

Taking Responsibility

"The decision to eat or not to eat a product is up to the parents and child," Glueck continued. "People say they want free choice and less government interference, but if they get obese they still want the right to sue for their own poor choice."

Restaurant owner Ricchi was less pessimistic.

"Personal responsibility remains a strong American value," she testified to the Senate subcommittee. Citing a Grocery Manufacturers Association survey, she pointed out "89 percent [of Americans] say personal lifestyles—lack of exercise or watching television"—are most responsible for obesity among Americans.

She also reported, "According to National Restaurant Association research, an overwhelming 95 percent of Americans feel they are qualified to make their own decisions on what to order when dining out."

"What people eat is ultimately a matter of personal choice," agreed Roger Deromedi, co-CEO of Kraft. "But we can help make it an educated choice."

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

INTERNET INFO

The full text of Rep. Ric Keller's H.R. 339, the Personal Responsibility in Food Consumption Act, is available through *PolicyBot*. Point your Web browser to **http://www.heartland.org**, click on the *PolicyBot* icon, and search for document **#12548**.

Testimony presented to the June 19 hearing on Keller's bill is available on the Internet at **http://www.house.gov/judiciary/commercial.htm**.

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Attack on Fast Food Jeopardizes Public Health Community

Elizabeth M. Whelan

Attorney John Banzhaf, who for years has litigated against tobacco, purportedly in an effort to protect public health, has announced his intention to solve another public-health problem—obesity—by suing fast-food restaurants.

Banzhaf declared in July that cigarettes were not, after all, the only legally available product that is both addictive and hazardous when used as intended, and that cigarette manufacturers were not the only ones who covered up the hazards of their product.

Banzhaf's argument—that so-called "fast food" fare, like cigarettes, is addictive and causes illness and death—is ludicrous. Food supports life and contributes to obesity only when it is overused—that is, when we consume more calories (regardless of the source) than are expended in exercise.

You will become overweight whether your excess calories come from beer, butter, beans, or burgers. True, many fast-food establishments serve up some gargantuan portions that can, in one sitting, get you close to the desirable calorie finish line for the entire day. But ultimately, consumers need to be responsible for what and how much they consume.

The credibility of the public health community is now in severe jeopardy. We who have dedicated our careers to science-based efforts to reduce premature disease and death should vehemently protest Banzhaf's tactics. Legal actions that may be appropriate against makers of cigarettes, a product that kills about half of its users, are clearly outrageous against firms that sell safe, nutritious, wholesome foods.

Indeed, Banzhaf's proposed lawsuit against food chains calls into question his motivation—and that of some other anti-smoking advocates—in campaigns against cigarette companies: Were they based on public health concerns?

Over the years, I have frequently heard members of the anti-smoking community complain tobacco companies were "profiting by selling deadly products," leaving me to wonder if they thought it would be acceptable so long as the companies simply gave away their deadly products. What irked them more: the hazards of cigarettes or the profits?

"We who have dedicated our careers to science-based efforts to reduce premature disease and death should vehemently protest [attorney John] Banzhaf's tactics."

There is evident in the anti-smoking community a general antipathy toward corporations—not just cigarette makers—which has made it difficult for the movement to stay on message.

Those of us who are outspoken on the dangers of cigarettes but who also, for instance, argue that regulated food additives and pesticides do not pose health hazards, or that food irradiation and products of biotechnology are safe, are viewed with skepticism, as if we can't really be anti-smoking because we failed the general anti-industry litmus test.

Now Banzhaf's willingness to apply the same legal tactics against food that he used on companies selling life-threatening cigarettes suggests his agenda is mainly fueled not by health concerns but by a general contempt for profit-making enterprises, regardless of whether the product is hazardous or not.

To effectively respond to these assaults on food companies and distributors, it is essential to understand the ultimate grievance these self-appointed advocates have against corporations. It may not be tobacco, fat, sugar or calories—but profits. In some cases, the advocates, cloaked in the garb of public health, may actually be seeking to extract a portion of those profits for themselves.

The cruelest blow Banzhaf has dealt to public health, though, is ending the isolation of Big Tobacco. He has now lowered the burger and fries crowd to the same level as tobacco in the public health hall of shame. Cigarette manufacturers can now consider using a new slogan: "We're no worse than fast food."

Cigarette executives may be delighted Banzhaf has put fast food on the docket next to cigarettes, but those of us in the public health profession should not be.

Dr. Elizabeth M. Whelan is president of the American Council on Science and Health.

"A la Carte" Menus Encourage Kids to Eat Poorly

Conrad F. Meier

Reporting in the July 2003 issue of the *American Journal of Public Health*, registered nurse Martha Kubik and colleagues at the University of Minnesota's School of Public Health found school-age children who were allowed to choose food outside the standard school lunches ate more fat and fewer fruits and vegetables than the government recommends.

According to the U.S. Department of Agriculture (USDA), nine out of 10 U.S. schools offer "a la carte" lunch programs, which are not required to meet USDA nutritional guidelines. Those guidelines call for eating at least five servings a day of fruits and vegetables and getting no more than 30 percent of calories from fat.

Consumer and parents' groups have begun complaining about the a la carte menus and school vending machines, which offer children more snack foods alongside the traditional, more nutritionally balanced, standard school lunch offering. But until now, little scientific research has been done into the effects of offering children such choices.

"This is probably the first paper that looks at the 'a la carte' programs in schools and their influence on student dietary behavior," said Kubik. Her research team collected data from 16 middle schools, three of which did not offer a la carte alternatives. They took detailed notes on what the teenagers ate for the previous 24 hours, not just what they ate at school.

Kubik's study suggests schools offering students pizza and fries as alternatives to healthier lunch choices are not only encouraging children to eat high-fat foods during lunch hour, but after school and at home as well.

"A la carte availability was inversely associated with fruit and fruit/vegetable consumption and positively associated with total and saturated fat intake," reported Kubik and her colleagues. "Snack vending machines were negatively correlated with fruit consumption."

Despite her research findings, Kubik said she did not believe school districts would easily give up a la carte. The programs have become an important revenue source for school food services programs. The USDA says a la carte sales generated an average of $913 per 1,000 students in the 1998-1999 school year.

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

INTERNET INFO

The full text of "The Association of the School Food Environment with Dietary Behaviors of Young Adolescents," authored by Martha Kubik, Leslie A. Lytle, Peter J. Hannan, Cheryl L. Perry, and Mary Story and published in the July 2003 issue of *American Journal of Public Health*, is available on the Internet at **http://www.ajph.org/**. The *Journal* charges $7 for reprints. Kubik's email address is **kubik002@umn.edu**.

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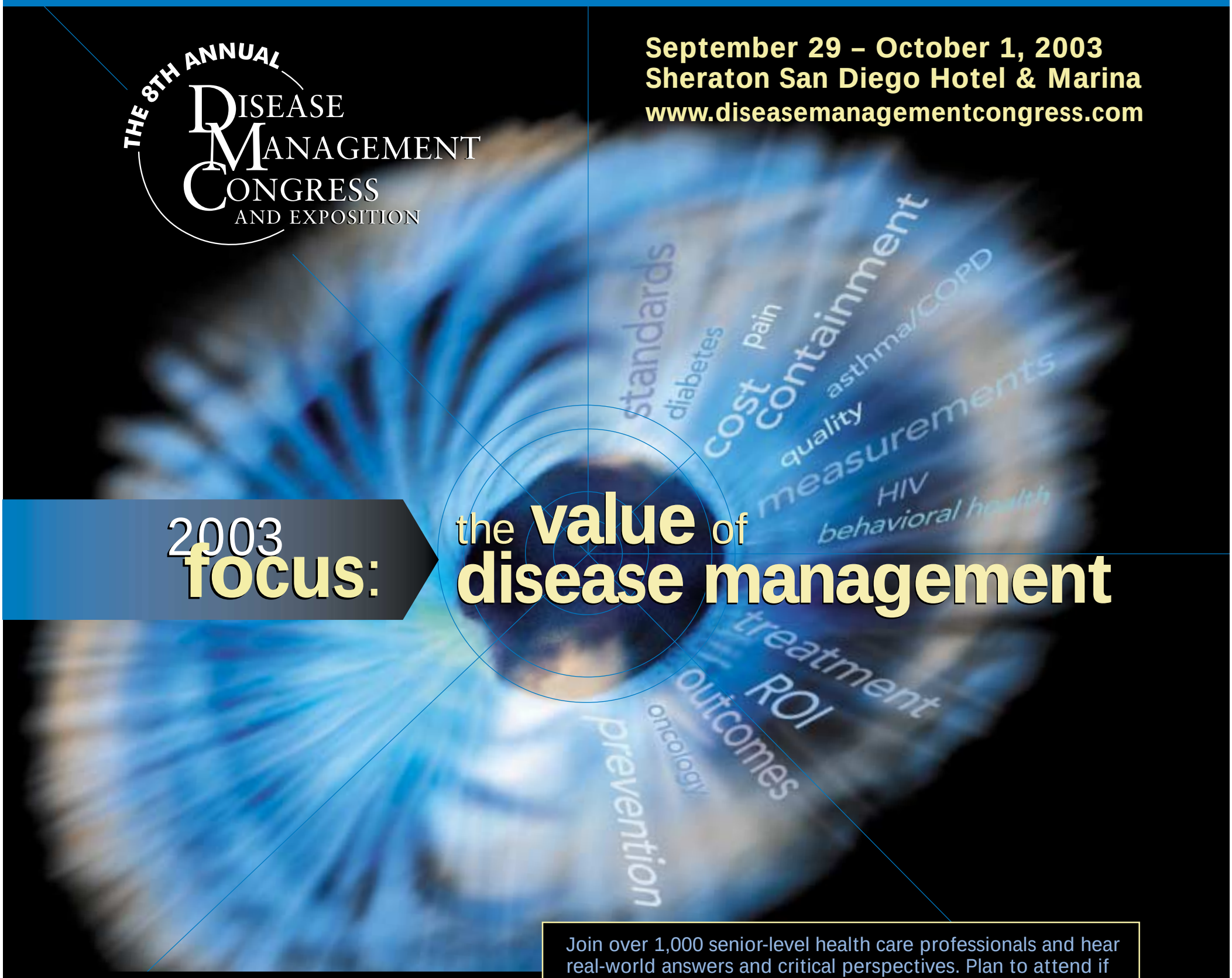

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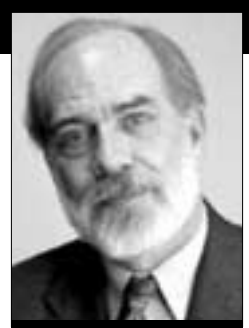

Greg Scandlen

All In a Day's Work

I'm swimming in a sea of health economists at the "Fourth World Congress of the International Health Economics Association." There are nearly 1,000 people listed as "presenters" and another 1,000 or so attendees. The "program at a glance" brochure is 70 pages long.

I'm here at the invitation of Bob Woodward of the University of New Hampshire, who presented a paper arguing the focus on outcomes and "medical necessity" misses the true utility of much of health care, which involves "consumer amenities" along with "investments" in improving health.

Amitabh Chandra of Dartmouth presented new research showing the timing of child birth is often one such amenity, and people increasingly use C-sections and induced labor to have babies during weekdays, thus avoiding holidays and weekends.

I said health care costs have been in a state of crisis since 1970, and we will never know whether our spending on health is rational until we reduce third-party payment and enable people to make their own spending decisions in competition with everything else they might spend their money on.

Uwe Reinhardt of Princeton said we need to decide how much of health care should be "socialized" and made available to everybody. Once that has happened, people should be free to spend additional money on amenities if they want to.

In a discussion way too short, we approached something of an agreement: That is, the United States already has an implicit floor of guaranteed assistance to all Americans of approximately $1,000 per person. That is roughly the per-person value of the exclusion from taxes of employer-sponsored coverage, and it is also roughly the amount of money we spend taking care of the uninsured.

Interestingly, it is also roughly what President George W. Bush has suggested as a tax credit for people who do not get employer coverage. I would prefer to have this subsidy made explicit and available to everybody through a tax credit for all to replace the exclusion as well as Medicaid. People could then buy their own preferred coverage.

Uwe would probably prefer it to be provided directly either through a government insurance system or direct provision of services. But we both agreed that beyond that baseline coverage, people should be free to spend their own money the way they want to.

Not bad for a day's work.

"Accident of History"

Whatever they do on the Hill, the market continues to move in the direction of empowering consumers. The *Florida Times-Union* ran an editorial noting employer involvement in health insurance is "an accident of history." Consumers now pay, it says, only one dollar for every five dollars of the costs—"If people paid only one-fifth of the cost of steak at the supermarket, few would eat hamburger."

But ultimately people are paying the other four dollars as well, it is just "spread throughout the economy ... and reflected in lower wages and higher prices everywhere." The article predicts rising costs will "spark new interest in medical savings accounts."

Source: **http://www.jacksonville.com/tu-online/stories/062003/opi_12835788.shtml**

"Consumers Are Pretty Smart"

Writing in the *Green Bay Press-Gazette*, Richard Ryman describes the new consumer-driven products being offered by Humana and American Medical Security, both of which are making use of HRAs but also offering a wide range of choices for employees and using Web-based tools "to help enrollees decide which plan suits them best."

A benefits manager for Plexus Inc., which is using Humana's SmartSuite product, reports 14 percent of its 3,200 employees signed up for the consumer-driven plans in the first year. She says, "Teaming up with Humana is helping us to teach our employees about just basic things. The same drug at Shopko costs different than at Copps. Employees didn't understand that before and they didn't need to because they just paid a $4 co-pay." Humana CEO Mike McCallister says, "Consumers are pretty smart. They are good at picking what's good for them."

Source:
http://www.greenbaypressgazette.com/news/archive/biz_10511157.shtml

Last Chance Before National Health Insurance

Bill Brewer reports in the *Knoxville News-Sentinel* that insurers are "turning to consumers to rein in costs in what some observers say is a last chance at keeping health insurance out of the federal government's hands."

The article is a report on a recent health care forum held in Knoxville. The chief medical officer of the Tennessee Blues, Dr. Steven Coulter, thinks physicians, insurers, employers, and employees have to "work together to control costs." He cites his son as an example of an uninformed consumer who "believes a visit to the doctor costs $10. He doesn't see medical care as expensive and he doesn't make judicious choices."

An actuary with Milliman USA, Doug Proebsting, reports "62 percent of U.S. employers surveyed by Milliman said they plan to move toward consumerism this year or next ..."

The article also notes spending on health care is up 675 percent in Tennessee over the past 20 years, compared to 450 percent nationally.

Source: **http://www.knoxnews.com/**. *This is another one of those pubs that charges to retrieve archives. The original article ran in the business section on June 15, 2003.*

Rejecting Consumerism

Writing in the *Dayton Daily News*, Kevin Lamb reports on a local coalition taking a different approach. The Tri-River Healthcare Plan has rejected consumerism in favor, it says, of improving quality.

Hugh Becker, the human resources vice president at Robbins & Meyers, thinks consumerism does nothing more than "shift costs from employer to employee." He says consumer plans "expect too much of consumers who have never felt the need to comparison shop."

Instead, Tri-River is working on physician behavior, "rewarding doctors for following best treatment protocols ..." It relies on a committee from the Greater Dayton Area Hospital Association to decide what protocols should be rewarded.

Source: **http://www.daytondailynews.com/business/content/business/daily/0616insurance.html**

Where's the Crisis?

Finally, Richard Quinn denies there is any crisis in health care, in an article in *Employee Benefit News*. He says people have been talking in terms of a crisis for 30 years or more, but "the fact is that the vast majority of Americans obtain health care when needed and the majority is satisfied with the system."

He does blast employers for being "shortsighted and strategically ill-informed ..." He says, "Employers were happy to build the entitlement mentality when it suited their needs," but now that times are tougher, they are willing to break their promises to their employees. He says doing that misses the importance of having a productive and loyal workforce, and will rebound on employers eventually.

Source: **http://www.benefitnews.com/subscriber/Article.cfm?id=37881153**

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Pennsylvania Senator Opposes Drug-Pricing Proposal

Managing Editor's note: On June 23, 2003, Senator Rick Santorum (R-Pennsylvania) rose to the Senate floor in opposition to a proposal by Senator Mark Pryor (D-Arkansas), who sought to mandate that prescription drugs be sold in the United States at the same price manufacturers charge in Canada. The Pryor proposal was defeated, but similarly dangerous language remains in the Senate version of the Medicare reform bill.

Santorum's floor speech, edited for space considerations, is reprinted below. Subheadings are inserted for the reader's benefit. The unedited text is available through *PolicyBot*. Point your Web browser to **http://www.heartland.org**, click on the *PolicyBot* icon, and search for document **#12503**.

Mr. President, I rise in opposition to the Pryor amendment. I do so in the strongest terms.

We had a debate on the issue of reimportation of drugs from Canada. The Senate spoke and said that if the Secretary of Health and Human Services would declare such reimportation was safe, we could then bring these drugs across the border at a reimported price.

Many on this side of the aisle, and I am sure a few on the other side of the aisle, voted for that amendment, as amended by Senator Cochran for that safety measure, basically concluding the Health and Human Services Secretary would never determine these drugs would be considered safe, since the Canadian government itself said they could not guarantee they were safe. We have all sorts of problems today with counterfeit drugs, drugs getting shipped in from other countries, leading to a variety of health problems. There was a great amount of comfort.

The Pryor amendment goes one step further, according to my understanding, saying if the Secretary does not say the drugs are safe within a period of time—I believe it is two years—then prices of drugs in this country will be set by the Canadian government, which I find a startling concession of authority of this government to a foreign country; that we are going to have a foreign country and a board in a foreign country set prices for drugs in the United States of America.

It is a remarkable concession for the Senate. I know we have a great desire to control many things in the United States. We would like to set prices, I am sure, on lots of different items. We do it in the Agriculture bill all the time. Now we are going one step further. If you cannot win price controls by having the Senate pass a price control bill, delegate the Canadian government to control the prices for you.

Why Canada?
Why Only Drug Prices?

Maybe we should choose different countries. Why Canada? Maybe there are other countries that set even lower prices than Canada. Why not choose them if we really want to save consumers money?

If this amendment is adopted, I would probably offer amendments that we should have chicken prices set by the Canadian government, wheat prices set by the Canadian government, and lumber and timber prices set by the Canadian government. Maybe it would just be good to have the Canadian government set all our prices in this country for those items we think are important. Obviously, they are very thoughtful in Canada, and they know what is best for us here, and we should just go ahead and let them set our prices for us.

We are not talking about the Canadian marketplace setting prices. We are talking about the Canadian government.

Drug Pricing in Canada

Want to sell your drug in Canada? First, you have to get it approved—get it on the formulary. You cannot sell drugs other than those approved by the Canadian government.

Government officials say to the drug company: OK, Pfizer, you want to sell your drug here? Great. We will pay you $1 a pill.

Pfizer responds: This costs us $1 billion to research. It is a great drug. It solves all sorts of problems. We sell it in America for $10 because of the enormous cost of the research and testing to make sure it is safe and efficacious, and it cost us a lot of money, and we have only a short patent life in which to recoup the investment dollars. We have a lot of drugs we tested along the way to find a cure for this problem, and we have to recoup those costs; otherwise, we cannot stay in business, we cannot continue to research.

The Canadian government says: That's nice; we'll pay you $1 a pill.

Pfizer says: No, we can't sell it for a dollar.

The Canadian government says: Then you can't sell your drug here.

And Pfizer loses out on a market of millions of people.

And under Canadian law, the Canadian government has the right to steal Pfizer's patent and give the formula for that drug to a generic drug manufacturer in Canada for them to produce at the dollar price Canada is willing to pay. They can steal a patent a company in this country spent millions of dollars, perhaps billions of dollars, to come up with, and then set a price in Canada at the level they choose.

The Senator from Arkansas wants to condone that behavior and require that we charge the same price in this country.

I cannot imagine anything that would be more damaging to an industry that does more than any industry in America to solve our health problems. They spend more on research and development than any other group of companies that exists, and they bring through drug after drug and therapy after therapy to extend lives, to increase the quality of life, and to cure diseases.

And we are considering in the Senate to reward that industry by allowing a foreign government to set prices for an industry that does not exist in Canada but it does exist in the United States. The majority of new drugs in the world are researched and developed in the United States.

"I know we have a great desire to control many things in the United States. ... Now we are going one step further. If you cannot win price controls by having the Senate pass a price control bill, delegate the Canadian government to control the prices for you."

A Better Way

Yes, we do pay more for drugs in this country. I will concede that to the Senator from Arkansas. And the reason we pay more for drugs here is that we do not regulate prices, as most other countries around the world do.

I think the Senator from Arkansas is on to something. We need to do something about those prices around the world. But it is *not* to adopt them in this country; it is to get the trade administrator to start putting these issues on the table when it comes to negotiating free trade deals.

They have to put on the table the pirating of our patents, with our free trade partners such as Canada and Mexico. They have to put on the table the prices they pay for drugs that are researched in this country that our people in this country subsidize. Yes, we do. In fact, we subsidize the world's research in pharmaceuticals.

And the Senator from Arkansas says we are going to stop doing that. We are going to do what Canada does, which is not subsidize one nickel of the cost of researching these new drugs—what Germany does, what England does, what most of the developed world does. They all piggyback on America.

Dangerous Consequences

What would be the consequences of the Senator's proposal? I do not think it takes an expert in pharmaceuticals to figure out exactly what happens.

We will squeeze the research dollars out of the drug-making industry, because we will be paying them based only on their cost of manufacturing. So the dollars to spend on research and development for that next generation of drugs will be gone.

Maybe that is a good idea. Maybe it is more important to have people get their drugs inexpensively today than to find that cure for cancer, diabetes, or Parkinson's, or to develop a new drug to ease symptoms of HIV. Maybe it is more important for someone to have their drugs a little cheaper today.

But there are millions of Americans, and even more millions of people around the world, waiting for that little pill that is yet to be discovered that will extend their life so they can see their daughter or grandchild being born, waiting for someone to cure that disease they are saddled with today, to give them just a few more months or a few more years.

And when a researcher walks into the office of someone who votes for this amendment, seeking NIH research dollars for diabetes, or for AIDS, Parkinson's, cancer, or heart disease, I want that Senator to say to them: Yes, we can give you government research dollars, but no one is going to take your research and put it to practical use, because I voted for this amendment and now we have squeezed every research and development dollar out of the pharmaceutical industry, so it has no incentive to take your research and do something with it to put it into commercial use and make that drug available.

Even though we are passing a pre-

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SANTORUM: Allowing Canadian government to set prices for drugs sold in the U.S. "a startling concession of authority to a foreign government"

scription drug benefit that is going to extend pharmaceutical benefits to make drugs less expensive, that's apparently not good enough. We also have to take a bite out of the hide of those nasty pharmaceutical companies. They get beaten up a lot ... until they are needed, until they extend your wife's life or save your child's life; then the rhetoric tones down quite a bit.

Not a "Free Vote"

We are shooting with real bullets here. This is a Medicare pharmaceutical package that will pass and turn into law. Anybody who thinks this is a free vote—that we can go back home and campaign and say, gee, I am going to get you cheap drugs— understand what this vote means. When that 7-year-old diabetic walks in your office, understand what you have done. It is as real as denying them the cure that is sure to come.

I know it is not popular to stand up for pharmaceutical companies. Maybe we should do to them what we have done to a lot of industries that have been successful in America: Beat them up, tax them, take their profits away, until they become dependent upon us, and then we will give them loan guarantees and bail them out. I think that is a very bad approach.

The right approach is to provide coverage for those who are in need of insurance to help them with their prescription drug bills, while at the same time allowing one of the most vibrant industries we have in this country to survive and thrive. That is the balanced approach. It is not attacking the very companies that are providing life-saving drugs for millions of Americans and millions around the world.

Even if you are for drug reimportation, this is a fundamentally different thing. This is completely changing the drug pricing structure of the United States of America and delegating it to a foreign entity.

I strongly suggest that if you want to do that—if you want to set drug prices—let's have an amendment to set drug prices. Let's not delegate it to the people of Canada to set our drug prices. Even if you are for reimportation, even if you are for cheaper drug prices, don't let the Canadian government do it. Get the glory of setting it ourselves, if we want to do something.

Zogby survey shows seniors doubt drug benefit coverage

Continued from page 1

but they are very skeptical about the impact of the proposed free-standing drug benefit.

Congress is currently debating the largest expansion of Medicare in its history. The survey thus was conducted in "real time," while the issue is attracting substantial attention in the press and generating much discussion among taxpayers, voters, senior citizens, and the general public.

Zogby surveyed by telephone 1,007 likely voters nationwide. The poll has an overall margin of error of ± 3.2 percent, with the margin slightly higher for poll sub-samples. Among the poll's findings:

- 82 percent of all voters surveyed and 67 percent of seniors agreed "seniors should have the option of picking a private health plan approved by the Medicare program to provide their health benefits."
- The drug benefit being debated in the Senate was described to those with drug coverage, who were then asked if it would be better than the coverage they currently have. Seventy-four percent of seniors said it would be no better, while 16 percent said it would be better.
- Of seniors without drug coverage, 43 percent said they would be likely to buy the new policy (16 percent "very likely" and 27 percent "somewhat likely").
- 66 percent are worried "a government-provided prescription drug benefit might mean that some people could lose their private health care coverage and become more dependent on government funding."
- 78 percent said "if the government gets into the business of providing a prescription drug benefit for Medicare ... the government would eventually control what drugs are produced and developed."
- 77 percent overall and 80 percent of seniors agreed "seniors should have to pay something for their prescription drugs to keep the Medicare program from going broke and so the next generation of seniors does not become a greater burden on future taxpayers." Only 18 percent overall and 15 percent of seniors said they should be entitled to all the drugs they need, "even if it puts serious financial strains on the Medicare program."
- Seniors also were asked if they would support a plan that provided $600 on a drug card for lower income seniors, with protection from large drug expenses starting at $2,000. Seventy-five percent supported such a plan. Voters were evenly split—44 percent to 44 percent—over whether the federal government or private health plans "would do a better job of getting lower prices on prescription drugs for seniors."
- 51 percent said they would support increasing the eligibility age for Medicare to 66 or 67, while 48 percent would not support such a move. Those already over age 65 supported the change by an even wider 61-36 percent margin.

Newsmakers

Blanche Gagnon, left, 93, and Cecile Snow, 94, attend a lunch at the Hi-Swans Senior Center in Swanton, Vermont. Both seniors consider themselves lucky to be relatively healthy, which allows Medicare to cover the costs of their prescription drugs. Many of their fellow seniors are unable to pay the high costs of prescription drugs and either go without or cross into Canada.

"A Zogby International opinion poll ... found overwhelming public support for private-sector options in Medicare ... as well as fear the complex drug benefit crafted by the Senate could be worse than the cover- age many seniors now have."

Skepticism, Confusion

In addition to showing widespread skepticism about a government-provided drug benefit, the poll also reflects some of the confusion on Capitol Hill, particularly regarding the impact of price controls or administered pricing.

For example, voters were evenly split over whether the federal government or private health plans "would do a better job of getting lower prices on prescription drugs for seniors." However, the survey shows voters are concerned that if the government gets into the business of providing a prescription drug benefit for Medicare, it would eventually control what drugs are produced and developed. This would be a particular concern with the "fall-back" drug benefit plan in the Senate bill.

Further, voters seem much more inclined to opt for private-sector plans if they are "approved by Medicare" (82 percent) than when that protection is not provided (54 percent). Younger voters are more inclined than seniors to be interested in a private-sector option for Medicare. This suggests Congress should consider laying the foundation now for a competitive model Medicare program that will be in place and ready for the influx of Baby Boomers beginning in eight years.

Grace-Marie Turner is president of the Galen Institute. Her email address is **galen@galen.org**.

INTERNET INFO

The full survey report is available in Adobe Acrobat's PDF format at the Galen Institute Web site, **http://www.galen.org/news/Medicare_Survey.pdf**.

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Asbestos litigation

Continued from page 1

financed by industry and insurers, would resolve hundreds of thousands of asbestos claims. Some 67 companies already have been driven into bankruptcy by claims both legitimate and spurious.

More than 200,000 asbestos tort claims are pending nationwide against more than 8,000 corporations. Many of the defendant companies never made asbestos products. The Senate measure would end those lawsuits and protect firms against any future suits asbestos victims might bring.

Medical Criteria Set

In June, Judiciary Committee members reached agreement on language describing the medical criteria that would be used to evaluate asbestos injury claims submitted to the proposed compensation fund.

The medical criteria approved by the committee include five levels of nonmalignant disease and five levels of cancer, including lung cancer and mesothelioma. Colorectal cancers and cancers of the throat and stomach could also qualify for compensation if the victim can show 15 years of occupational exposure to asbestos and medical documentation that the exposure contributed to the disease.

"Emergency room physicians are trained to 'triage' their patients according to the severity of their injuries and illnesses," noted Tom Miller, director of health policy studies for the Cato Institute. "We've reached that point long ago in the litigation lottery for asbestos claims that are real, minor, and imaginary. Future compensation must be based on the severity of medical distress."

Compensation Levels Set

Shortly after the medical criteria for compensation were established, the Judiciary Committee also reached agreement on the amounts the trust fund would pay to claimants in each of the 10 categories. Compensation would range from $20,000 for persons claiming "mixed diseases with impairments" to $1 million for those suffering mesothelioma, a rare form of cancer linked to occupational exposure to asbestos.

Injury claims would be heard by 20 special "asbestos masters," who would be appointed to work through the existing U.S. Court of Claims, instead of in a separate asbestos court as Hatch originally proposed. Claimants would not be required to hire a lawyer to qualify for compensation.

Of the compensation fund's $108 billion price tag, $104 billion would come from insurers and manufacturers. That's up from the $90 billion Hatch proposed in his original bill, and insurers strenuously objected to the increase.

The bill was "supposed to provide fairness and finality," said Julie Rochman, speaking for the American Insurance Association. "It doesn't do either."

How Much Is Enough?

Democrats and labor union representatives also objected to the bill. Senator Dick Durbin (D-Illinois) said "more money should be on the table," and the AFL-CIO's Peg Seminario agreed, saying the measure would "leave the vast majority of asbestos victims without compensation."

Proponents of the measure countered the fund is needed to make sure victims with documented health impairments are compensated, quickly and without the expense of hiring a trial lawyer.

Most of the plaintiffs in currently pending asbestos litigation show no evidence of illness or other physical harm from asbestos exposure. Nevertheless, some are being awarded large judgments based on what critics say is highly speculative future harm, suspect science, and juries' preconceived notions about asbestos.

Without a national compensation fund, proponents warn, asbestos claims both legitimate and spurious will bankrupt companies long before most victims can be compensated.

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leahy.senate.gov

Senator Patrick Leahy (center) works with Chairman Orrin Hatch (R-Utah) and Senator Edward Kennedy (D-Massachusetts) during a July 10 Judiciary Committee meeting aimed at reaching an agreement on asbestos litigation reform.

Greetings from the Sausage Factory

Greg Scandlen

The old saw is if you like sausage or legislation, avoid watching either being made. Here's a case in point.

HR 2351, sponsored by Ways and Means Chairman Bill Thomas (R-California), seemed a pretty straightforward revision of MSAs, and added a $500 FSA rollover. It allowed first-dollar coverage of preventive services, lowered allowable deductibles to $1,000 and $2,000 for individuals and families, allowed 100 percent of the deductible to be contributed each year, allowed combined employer and employee contributions, and removed the limits on employer size and total enrollment. Simple, eh?

Not so fast. During mark-up in the Ways and Means Committee all kinds of strange things happened. A "substitute amendment" was offered that changed all of that. I was traveling all week, and when I got back it was (and still is) hard to sort out what happened. Although the legislative language is incomprehensible, it appears the substitute lowers the allowable deductibles to $500/$1,000 but allows individual "Health Savings Account" contributions of up to $2,000 and $4,000. That is, the contribution is no longer tied to the size of the deductible. People eligible to make these contributions would have to have a "qualifying" insurance plan or be uninsured.

What particularly alarmed people was the addition of a means-testing provision. The substitute set an income limit of $45,000 for individuals and $65,000 for families, similar to the IRA contribution limits. At first it wasn't clear what this limit applied to. Would HSAs be available only to people at these income levels? If so, how in the world would an employer be able to offer it as a benefit plan?

Digging deeper, it appears the income limits apply only to the individual contribution to the HSAs, not to eligibility itself. Employers could go ahead and offer HSAs to the entire workforce, and contribute money to the HSA regardless of a worker's income.

At this writing, we are told the means testing provision has been dropped. We also understand both the original MSA expansion and the HSA substitute will be in the bill when it goes to the floor. But the bill is still being worked on, so I wouldn't place any bets.

The substitute created quite an uproar. Ways and Means was apparently deluged with complaints. The core idea isn't bad—allow people to set up a Health Savings Account independently of their employer or of their underlying insurance coverage. In fact, I proposed precisely this in my Unified Health Account paper earlier this year. Apparently the income provisions were inserted to pacify the Joint Tax Committee's estimate of the revenue loss. But there are ways to do that other than introducing a whole new idea for income testing. They might have reduced the allowable annual contribution to $1,000/$2,000 or $1,500/$3,000, for instance.

More importantly, the substitute was completely unexpected by the consumer health community. We were looking for a simple expansion of MSAs, and suddenly we have all these other things with next to no information about the whys and wherefores. Who was it that said, "What we have here is a failure to communicate?"

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INTERNET INFO

For more information on HR 2351, the Health Savings Account Availability Act, see **http://thomas.loc.gov/cgibin/bdquery/z?d108:HR02351:@@@M**

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GALEN INSTITUTE
A MONTHLY REVIEW OF HEALTH POLICY MATTERS

Grace-Marie Turner

RECENT ARTICLES & STUDIES

Health Insurance Spending Growth: How Does Medicare Compare?

Joint Economic Committee
June 20, 2003

The Joint Economic Committee compares spending increases over 20 years for Medicare, the Federal Employees Health Benefits Program (FEHBP), and the California Public Employees' Retirement System (CalPERS), as well as private health insurance and Medicaid.

The JEC finds the FEHBP's cost control is slightly better than Medicare's, even though the FEHBP offers more comprehensive coverage. FEHBP premiums grew at an average rate of 6.5 percent between 1983 and 2002, while Medicare's average annual rate was 6.7 percent.

Full text (pdf): **jec.senate.gov/JEC%20%20Health%20Insurance%20Spending%20Growth.pdf**

The GOP's Medicare Surrender

Wall Street Journal
June 11, 2003

"What began as a worthy attempt by President Bush to reform the broken retiree health system is fast becoming in Congress little more than a giant new entitlement," writes the *Wall Street Journal* in an editorial.

The GOP Senate bill may look like real reform, but a closer look finds bad ideas like competitive bidding that will limit choice. "Worse, these private providers would be reimbursed based on a traditional Medicare price benchmark—in other words, based on a price-control system that is already driving many doctors out of Medicare," writes the *Journal*.

"The better reform alternative is to offer the drug benefit only as part of an integrated insurance plan just like most working Americans have," writes the *Journal*. "And rather than picking winners, the government could let seniors choose for themselves."

Full text (requires subscription):
online.wsj.com/article/0,,SB10552890394296 8700,00.html?mod=opinion

Daschle Doesn't Get it

Robert Moffit
National Review Online
June 11, 2003

Senator Tom Daschle fails to note "the average Medicare patient pays roughly $2,000 per year to cover the shortfalls" in coverage or to recognize "the crisis situations that have erupted in some cities because doctors refuse to take on new Medicare patients," writes Bob Moffit of The Heritage Foundation.

There are signs all over the country Medicare is in trouble. In Denver, the share of doctors accepting Medicare patients is down 52 percent from 2001; in Seattle, the percentage has gone from 71 percent to 55 percent in four years. Moffit quotes Dr. Lois Copeland, a New Jersey physician, "who said she has lost two patients recently because doctors refused to operate."

Medicare "doesn't work for doctors or hospitals, which are fed up with its slow reimbursement, more than 111,000 pages of rules and paperwork, and a nearly indecipherable price-control system," Moffit writes. "Increasingly, it doesn't work for patients, who are finding it harder and harder to locate a doctor."

Full text: **www.nationalreview.com/comment/comment-moffit061103.asp**

Dangerous Drug Plan

Robert Goldberg
Washington Times
June 11, 2003

"Prescription drug coverage for seniors is truly the Twilight Zone of American politics," writes Robert Goldberg of the Manhattan Institute.

Current Medicare drug proposals "do not solve the problem of seniors who are truly unable to purchase a prescription because of cost, and they do not encourage seniors to obtain comprehensive coverage through health plans. The perfectly targeted policy for insuring access" would help lower-income seniors without coverage—and the cost would be far less than the $350 to $400 billion Congress is expected to spend on a Medicare drug benefit.

Full text: **www.washtimes.com/op-ed/20030610-094627-5565r.htm**

A Costly Freebie

Robert J. Samuelson
Washington Post
June 4, 2003

Adding a prescription drug benefit to Medicare "would simply worsen the country's central budget problem: the huge retirement costs of the baby-boom generation," says Robert Samuelson, a columnist for the *Washington Post*.

"From 2010 to 2030, the over-65 population is projected to rise by about 30 million; meanwhile, the working-age population (20-64) will increase by only 10 million," compounding the pressure for younger families to pay for Social Security and Medicare benefits.

Samuelson says there are three reasons the costs of a drug benefit are dramatically understated: 1) costs will rise rapidly after baby boomers reach eligibility, starting in 2011; 2) today's proposals cover half or less of the elderly's drug costs and seniors will agitate for improvements; and 3) a new Medicare drug benefit will encourage more drug use.

Full text: **www.washingtonpost.com/wpdyn/articles/A10494-2003Jun3.html**

The promise of a Medicare drug benefit has been transformed from a political football into a steamroller, and at least one thing is clear: The bill is based on bad policy.

Grassley and Baucus insisted patients on traditional Medicare must get a drug benefit equal to those joining the new market-based option. That violates President George W. Bush's important principle—which the entire free-market policy community supports—that a new drug benefit should be a carrot to encourage seniors to join modern health plans that can provide better benefits.

Lawmakers made themselves insurance actuaries and wrote up the free-standing drug policy. Not surprisingly, it's complicated and not at all senior-friendly.

Nonetheless, at least two private drug plans must agree to offer this coverage in each region of the country. If they don't, the federal government would offer a fallback plan. This is straight from the Kennedy-Daschle playbook: a government-run drug benefit that's run much like the rest of Medicare, with the federal government inevitably fixing prices and deciding what drugs will be covered.

Seniors hoping the new market-based plans will be an option should note they will be paid based upon the flawed fixed government payment system that has driven Medicare HMOs out of business and is forcing more and more doctors to refuse to see patients on traditional Medicare. The requirement that the government pick the "three lowest bidders" in a region turns health care into a bargain-basement commodity.

The Medicare director during the Clinton administration, Nancy-Ann DeParle, said if Bush signs this bill, "he will preside over the biggest expansion of government health benefits since the Great Society." And she means this as a positive statement, encouraging Democrats to "speed the way" for the bill and fix its gaps later.

The *Wall Street Journal* observed Senator Ted Kennedy (D-Massachusetts) is supporting the bill because "we'll expand it over a period of time." The drug benefit is complicated and contains the dreaded doughnut hole, which liberals will try to fill—with more taxpayer dollars—as soon as they can.

Amazingly, the *Washington Post* editorialized against the proposal, calling it "a mishmash" and urging lawmakers to go "back to the drawing board." There's little chance of that.

As lawmakers proceed, they should be reminded of what happened the last time Congress passed a drug benefit for Medicare: in 1988, as part of the Catastrophic Health Care Act. The legislation was already on the books when seniors began to learn the details and they rebelled, beating with their umbrellas on the car of the measure's author, Dan Rostenkowski. The legislation was repealed a year later. Please, no instant replays.

Material for this report is provided by The Galen Institute, P.O. Box 19080, Alexandria, VA 22320. **http://www.galen.org**. *Grace-Marie Turner is president. The report was produced by Elizabeth Lamirand, who can be reached at 703/299-9550, and edited by Conrad F. Meier, managing editor of* Health Care News.

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MY **TURN**

Grandpa Conrad

Apologies to My Grandchildren

Dear Jack, Katie, Luke, Will, Tess, Elle, and Anthony:

My entire generation owes you an apology. But I can speak only for myself when I say I regret to inform you that you are going to get a hulk of a tax bill by the time you celebrate your 20th birthday.

I know you are still too young to fully understand, but while you are having fun chasing bugs and butterflies, the people who make laws in this country are playing pretend and saying they want to help old folks pay for some of the medication they take to feel better and live longer.

The very awful thing about this is that your Grandpa and Grandma and millions like us don't need this help ... and many of us don't even want it. About 75 percent of seniors already get medicine paid for with Medigap, Medicaid, Medicare+Choice, public assistance, employee retirement plans, and discount drug programs sponsored by the big companies who make the drugs.

These lawmakers are called Republicans and Democrats, and they will soon vote to pass what is called Medicare reform legislation. What all that really means is the government is going to spend a lot of money paying for what most seniors can afford to pay for themselves but, being selfish, would rather have someone else pay for.

That "someone else" includes people like your Mom and Dad. Why should they have to pay for someone else's medicine? It's called a "wealth transfer," like you getting two dollars for doing your chores and then having the big kid next door take one dollar away, leaving you with only one.

Problem is, as Mom and Dad get older, the taxes they pay won't be enough and the money will run out. So, the government will ask you to start paying the bill, and it will be huge. Right now they say it will cost $400 billion just to get it up and running.

It Gets Worse

In the 10 years after 2010 the bill will be about $700 billion. Soon after that you will have your own careers but you will be so heavily taxed you may not be able to afford a house or a car. You might not be able to take a long vacation or raise a family of your own. I'm sorry, I apologize—but it's not my idea!

Here's a little secret, so don't tell: While seniors make up only 12 percent of the population, we own more than half the financial and real estate assets in the country. Not only can most seniors afford the private insurance that pays for drugs, many seniors can even afford to pay cash. This new Medicare giveaway is not what most of us need. The money you will pay in taxes to fund it *is* something you will need in the future.

Hunting Bugs with a Bazooka

The folks who really need our help are those poor seniors and some very sick people who cannot help themselves. You all know we should share our toys and help those with no toys. The same goes for money.

A drug discount card subsidized by government and given to poor seniors would work to help just the folks who really need it. So would greater publicity and awareness of all those private-sector drug discount cards and patient assistance programs. Lots of people don't even know they exist.

There is also a very serious mistake in the Medicare drug giveaway. More than one-third—roughly 37 percent—of senior citizens who have employer-provided drug insurance will lose it under the current versions of the Senate or the House plans.

When that happens millions of seniors like Grandpa and Grandma would be forced to accept government-run Medicare. It is how government gets people hooked on giveaways so they have to keep voting for more giveaways. It's like people who use drugs and can't stop.

Doughnuts

The new government drug program would stop helping seniors after they spend a little money, and then start up again after they have spent lots more money. That has a funny name called the "hole in the doughnut." It's like eating through the outside until you get to the center and there's nothing there... but you are still hungry.

You can help stop this very bad social plan by calling or sending a letter to the people in Congress telling them to help just those folks who really need help and stop messing with your future. They will listen to you because politicians will do anything "for the sake of the children."

Tell them this is their chance to prove it.

Grandpa Conrad is Conrad F. Meier, senior fellow in health policy and managing editor of Health Care News. *Contact the old guy at* **meier@heartland.org**.

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Florida

Continued from page 1

at Medical Scientists, released on July 8, concluded Pfizer's program had saved the state's Medicaid program $15.9 million between December 1, 2001 and June 30, 2002.

Researchers found the program reduced hospital stays among the state's target group of Medicaid beneficiaries by 12.6 percent. The state was able to reduce expenditures for 4,810 high-risk Medicaid beneficiaries.

The policy review office of the state legislature, which opposed the program's renewal, estimated the state could save $64 million in the next fiscal year alone by eliminating the patient-centered program and forcing companies to offer drug discounts for Medicaid's poor, elderly, and disabled recipients.

Alternative to Drug Discounts

Pfizer first pitched the disease management approach to Governor Jeb Bush (R) in 2000, as he sought ways to reduce Medicaid drug costs. New York, Texas, and other states are currently considering similar programs.

"Pfizer, Bristol-Myers Squibb Co., GlaxoSmithKline PLC, and AstraZeneca PLC ... have guaranteed a combined total savings to Florida of $64.7 million over the two years ... or they'll pay the difference."

A well-run disease management system, proponents say, can dramatically improve patient outcomes and reduce medical costs by emphasizing the health of the patient as a whole, not simply focusing on the specific disease being treated.

With a serious condition—diabetes, for example—medication alone can do only so much. Better health outcomes can be achieved if the patient is also managed into a better diet, regular exercise, and a weight loss program; if the patient quits smoking and avoids excessive drinking; and if the patient is dedicated to monitoring his or her blood sugar levels. Patients who do not make such lifestyle changes often end up in emergency rooms for stabilization and require more visits to the doctor.

In the case of chronic diseases, experts say, poor patient management also can lead to the onset of additional health care problems requiring even more medications and hospital stays, all of which diminish the patient's quality of life and add to the total cost of health care.

Pharmaceutical companies are promoting disease management programs as a better way to cut costs than the drug price discounts more than a dozen states demand from them. By partnering with the states on disease management, the firms also get their medicines onto the state formulary of drugs preferred and approved for use by Medicaid patients.

Critics say disease management programs achieve less in Medicaid spending cuts than is achieved through mandated drug discounts. They also contend disease management programs may increase drug company sales and escalate Medicaid spending.

Proponents of the approach disagree, saying overall medical costs fall with disease management programs because patients spend less on doctor and hospital visits.

Bob Sharpe, director of Florida's Medicaid program, is a proponent of the disease management approach. While drug discount programs do save money, he said, such programs "do nothing to invest in people." As a result, Sharpe said, drug discount programs achieve savings only in the short term, while disease management programs have a more lasting effect.

Addressing Health Problems Early

Pfizer's Florida program—the most extensive of the four firms' offerings—was launched in July 2001. Roughly 60 Pfizer case managers work with 13,000 Medicaid recipients in the state. Pfizer's arrangement with the state allows the company to sell drugs to Medicaid patients without discounting their prices.

John Sory, vice president of Pfizer Health Solutions, insists the disease management approach makes sense because it can prevent patients from running up medical bills by addressing health issues before they become major problems. "We want to talk to people before they get sick," Sory said. He said the company's pricing policy in Florida is "well-reasoned and responsible," noting it strives to keep medications affordable for the poor.

Claiming he supports the preventive doctrine of disease management, Senator Walter Campbell (D-Fort Lauderdale) nevertheless opposed the pharmaceutical firms' program because it "forces" the state to give up millions of dollars in drug discounts. "All we're doing is giving big corporations the right not to pay us what they owe us," he asserted.

Others worry disease management programs raise a potential conflict of interest issue, because participating firms might favor their own drugs in the disease management programs they run. Pfizer's Sory insisted that "just does not happen."

Merrill Matthews Jr., Ph.D., director of the Council for Affordable Health Insurance, told *Health Care News*, "Florida has been a leader—on the one hand, in creating restrictive prescription drug lists and imposing supplemental rebates and, on the other hand, in creating innovative drug company alliances that implement disease management programs for people with chronic health problems.

"While both approaches were undertaken to save money," he continued, "the latter approach has the added benefit of likely improving health outcomes."

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

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